

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION


<b>Facility's Name: Senior Helpers</b>	<b>CHAPTER 700</b>
<b>Address:</b> <b>1350 S King Street, Suite 214, Honolulu, Hawaii 96814</b>	<b>Inspection Date: December 2, 2020 Initial (Home Inspection)</b>

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-700-8 <u>Policies and procedures</u>, (5)(B) A home care agency shall have policies and procedures that include:</p> <p>Requirements for the contents and maintenance of client records that shall include but not be limited to:</p> <p>Procedures for the staff to document information in the record about the services rendered to each client; and</p> <p><b><u>FINDINGS</u></b> Client #2- Review of the client's binder during the home visit on 12/2/20 revealed that the caregiver's last documentation of services rendered was on 10/2/20. Client is receiving services with the agency Monday to Friday from 8:00 a.m. to 12:00 p.m. Per agency policy, documentation of services provided must be completed by the caregiver every client visit.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>On 12/4, I asked the caregiver if she is writing and documenting notes of services and daily activities. Caregiver responded Yes, but client's tenant took the record sheet out.</p> <p>On 12/09/20, I requested for the caregiver to come into my office location to discuss the deficiency and we discussed that per the 11-700-8 and per agency policy, documentation must be completed by caregiver every client visit.</p> <p>Sent a employee conversation confirmation to document correction. The correction will be that all caregivers must send to supervisor their client care record at the end of each work week.</p>	12/20

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-700-8 <u>Policies and procedures.</u> (5)(B) A home care agency shall have policies and procedures that include:</p> <p>Requirements for the contents and maintenance of client records that shall include but not be limited to:</p> <p>Procedures for the staff to document information in the record about the services rendered to each client; and</p> <p><b><u>FINDINGS</u></b> Client #2- Review of the client's binder during the home visit on 12/3/20 revealed that the caregiver's last documentation of services rendered was on 10/2/20. Client is receiving services with the agency Monday to Friday from 8:00 a.m. to 12:00 p.m. Per agency policy, documentation of services provided must be completed by the caregiver every client visit.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>Administrator or supervisor will require each caregiver who is on a scheduled shift for an active client to send a copy of the Client care record at the end of each work week. to Supervisor or administrator.</p> <p>Additionally, an employee conversation confirmor and a signed ethics agreement will outline the requirement to document services provided by the caregiver every client visit.</p> <p>The caregiver will receive an violation occurrence up to termination if not completed.</p>	12-21-20

Licensee's/Administrator's Signature: 

Print Name: Karen Tienra

Date: 12-21-20